MEMORIAL COMMUNITY HEALTH, INC.
1423 7th Street
Aurora, NE 68818
402-694-3171

Dear Patient:

Under the regulations of Privacy of Health Information, you have the right to designate another person who can share in your health care and information. If you wish to name someone to receive medical information regarding your private records, please complete the following:

YOUR NAME_____**(please print)**

Medical Record #_____

I designate the following persons to receive medical information regarding my care:

_____	_____
Name of Person	Relationship to Patient
_____	_____
Name of Person	Relationship to Patient
_____	_____
Name of Person	Relationship to Patient
_____	_____
Name of Person	Relationship to Patient

_____	_____
SIGNATURE OF PATIENT	**Date**
_____	_____
Signature of personal representative of patient unable to sign	**Date**